

Correspondence

Unconventional Therapy

TO THE EDITOR: I would like to thank Dr Lewis for proving once and for all that unconventional therapy is the method of choice in patients with advanced cancer.¹ I am certain that this was not his intent, but in quoting the study by Cassileth and colleagues, this is precisely what he has done. His article states that in matched patients with advanced cancer, half of whom were treated at a large university medical center and half of whom were treated at a clinic that administered unconventional therapy, the survival time was comparable. In other words, state of the art oncology at a large university medical center was unable to provide a better survival rate than a clinic providing unconventional therapy. In light of the mammoth costs associated with the large medical center and because the survival rate is comparable, why would anyone opt for the expensive oncologic therapy at the university when the results will be the same at a clinic using unconventional therapy?

If I am to take the responsible approach to addressing the problem of unproven therapies, as Dr Lewis suggests, what should I tell my patients—that for those with advanced cancer, unconventional therapy is just as effective as conventional therapy?

GREGORY D. TAYLOR, MD
Mountain Medical Associates, PA
PO Box 242
Sun Valley, ID 83353

REFERENCE

1. Lewis JP: Clinical studies with make-believe drugs. *West J Med* 1992 Dec; 157:677-678

* * *

Dr Lewis Responds

TO THE EDITOR: The Cassileth study cited by Dr Taylor and me was designed to compare the outcome of patients with far-advanced cancer cared for at a large academic medical center with those treated at the Livingston-Wheeler Clinic, San Diego, California.¹ The patients had advanced, refractory colon or rectal cancer, malignant melanoma, or unresectable adenocarcinoma of the pancreas. The study predicted the survival rate would be similar in both groups, and it was. Medical oncologists seldom affect survival rates in these patients. They can improve the quality of life by addressing complications and assuring the patient and family that the medical management team and various support systems, including hospice, will be available to help.

The treatment used at the Livingston Clinic was an autogenous immune vaccine made against a microorganism, named by Dr Livingston-Wheeler, *Progenitor cryptocides*. The existence of this biologic entity has never been acknowledged by medical science; it is a make-believe microorganism, and thus the patients were being treated with a make-believe "vaccine." Using this "vaccine," the Livingston-Wheeler Clinic claims an 82% success rate with managing cancers.^{2,3} The public undoubtedly interprets this to mean that they cure many

patients or improve the quality of life of most. Cassileth's study refutes these claims. As mentioned in my commentary, the real lesson of this study was that the quality of life was better among patients cared for at the academic medical center. The patients did not live longer at the Livingston-Wheeler Clinic, and they had a reduced quality of life while under the clinic's care.

Dr Taylor wonders if, because patients did not live longer at the academic institution, unconventional therapy is just as good as standard management and maybe cheaper. Because costs of care were not calculated, assertions about expenses are inappropriate. Indeed, careful management by experienced oncologists may be less costly than management by practitioners who rely on make-believe therapies.

The purpose of my commentary was not to discuss the results of the study but to explore the ethical and human subject review aspects entailed in designing and carrying out a clinical protocol in which one of the arms employed an agent that did not really exist. I continue to think that such a study cannot be ethically carried out under human subject informed consent procedures.

Using therapies that have not been proved effective and that are based more on wishful thinking than solid scientific data is neither ethical, efficacious, nor proven to be economical.

JERRY P. LEWIS, MD
Professor of Internal Medicine
and Pathology
University of California, Davis,
School of Medicine
1508 Alhambra Blvd, Rm 320
Sacramento, CA 95816

REFERENCES

1. Cassileth BR, Lusk EJ, Guerry D, et al: Survival and quality of life among patients receiving unproven as compared with conventional cancer therapy. *N Engl J Med* 1991; 324:1180-1185
2. Livingston-Wheeler therapy: Unproven methods of cancer management. *CA Cancer J Clin* 1990; 40:103-108
3. Livingston-Wheeler V, Addeo EG: *The Conquest of Cancer*. New York, NY, Franklin Watts, 1984

Health Care Reform—Epidemiology and the Science of the Sustainable

TO THE EDITOR: In a recent editorial on health care reform in the United States, Dr Clever articulates a diverse array of characteristics that will have to shape a reformed system.¹ She notes that "science is our particular intellectual underpinning" and refers to care that should range from the preventive through the acute to rehabilitative. As an epidemiologist who works at the preventive and public health end of the spectrum of the health care system, I would argue that to be sustainable, health care reform will require, in addition to these qualities, a fundamental revisioning of the system's orientation, its point of intervention in the causal development of disease, and, ultimately, a significant evolution in our general cultural values with respect to the locus of responsibility for individual health.